CONFIDENTIAL REPORT OF BLINDNESS OR VISUAL IMPAIRMENT
INDIANA STATE DEPARTMENT OF HEALTH
State Form 48126 (R/2-01)

PLEASE TYPE OR PRINT

NAME OF PATIENT: _____ SSN# _____
LAST FIRST MIDDLE INITIAL (VOLUNTARY)

STREET ADDRESS: _____ COUNTY _____

PHONE: ( ) _____ CITY _____ ZIP _____
5 DIGITS PLUS FOUR

DATE OF BIRTH: _____ AGE: _____ EXAM DATE: _____ SEX _____
Month/Day/Year Month/Day/Year M or F

RACE/ETHNICITY: WHITE ☐ BLACK ☐ HISPANIC ☐ NATIVE AMERICAN ☐ ASIAN/PACIFIC ☐
MULTIRACIAL ☐ OTHER ☐ UNKNOWN ☐

IS PATIENT DIABETIC? YES ☐ NO ☐ IF YES: TYPE 1 ☐ TYPE 2 ☐ UNKNOWN _____

This is to certify that I examined the above person on (date) _____
and the following is the result of visual testing with **best correction in the better eye.**
Check all that apply:

VISUAL ACUITY		**AND/OR**	**VISUAL FIELD**	
20/60 - 20/180 (Visually Impaired)	☐		45-70° in Diameter (Impaired)	☐
20/200 - 20/2000 (Legally Blind)	☐		21-44° in Diameter (Impaired 2)	☐
20/2000 (Motion Perception)	☐		20° in Diameter (Legally Blind)	☐
Light Projection Only	☐			
Light Perception Only	☐			
No Light Perception	☐			

DIAGNOSIS

Cataracts	☐	Glaucoma	☐
Diabetic Retinopathy	☐	Macular Degeneration	☐
Eye Injury	☐	Retinitis Pigmentosis	☐

Other: _____
_____

Please add comments regarding other significant information relating to visual status which may impact education, employment, and/or other activities:

_____
_____

- Patient given information on available services through the Blind & Visually Impaired Services and/or Vocational Rehabilitation; Division of Disability, Aging, & Rehabilitation Services; Indiana Family and Social Services Administration? Yes __ No __
- Patient refused information? Yes __ No __

Name of Optometrist or Physician (Print) _____

Name of Practice/University _____ Telephone No. ( ) _____

Signature of Physician or Optometrist _____ Date: _____

-Indiana Code (IC) 16-40-2-*1 Persons required to report. Each physician holding an unlimited license to practice medicine, or optometrist licensed under IC 25-24-1,* ***shall report in writing, on forms prescribed by the state department, not more than ten (10) days after diagnosis****, to the state department the name, age, and address of each person diagnosed by the physician or optometrist as being blind (as defined under 42 U.S.C. 416(i)) or having visual impairment of a degree to interfere with the person's functioning in school, employment, or other activities of daily living.* ***-IC 16-40-2-3****--Confidentiality. All reports filed under this chapter shall be kept confidential and used solely for the purpose of determining the eligibility of the individuals for assistance or rehabilitation.* ***-IC 16-40-2-7*** *Failure to report. A person required to make a report of blindness under this chapter who fails to do so commits a Class C infraction.*

Mail completed form to Vital Statistics; Indiana State Department of Health; Two North Meridian Street, 3-D; Indianapolis, IN 46204-3003.